FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATIC THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVI ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORI HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENT

I. IDPH Facility ID Number: 0035618

Facility Name: BRYN MAWR CARE INC.

Address: 5547 NORTH KENMORE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 561-7040 **Fax #** (773) 561-7543

IDPA ID Number: 363654908001

Date of Initial License for Current Owners: 08/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrato of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY C. BUXBAUM, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax: (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-163**

Facility Name & ID Numbe: BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	174	Intermediate (ICF)	174	63,570	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	174	TOTALS	174	63,570	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	58,553	907		59,460	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,553	907		59,460	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 93.53%

D. How many bed-hold days during this year were paid by Public Aid?
2147 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediar N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginnin 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	136,038	12,307	29,748	178,093		178,093	(17,810)	160,283			1
2	Food Purchase		205,745		205,745	(13,669)	192,076	(31)	192,045			2
3	Housekeeping	100,489	14,822		115,311		115,311	576	115,887			3
4	Laundry		16,279		16,279		16,279		16,279			4
5	Heat and Other Utilities			84,286	84,286		84,286	1,893	86,179			5
6	Maintenance	40,541		118,882	159,423		159,423	(54,673)	104,750			6
7	Other (specify):*							6,823	6,823			7
8	**TOTAL General Services**	277,068	249,153	232,916	759,137	(13,669)	745,468	(63,222)	682,246			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	760,153	16,954	155,533	932,640		932,640	(16,752)	915,888			10
10a	Therapy			15,456	15,456		15,456	(4,563)	10,893			10a
11	Activities	116,669	9,215	2,221	128,105		128,105		128,105			11
12	Social Services	180,666			180,666		180,666		180,666			12
13	Nurse Aide Training											13
14	Program Transportation			1,678	1,678		1,678		1,678			14
15	Other (specify):*							5,423	5,423			15
16	**TOTAL Health Care and Progra**	1,057,488	26,169	178,488	1,262,145		1,262,145	(15,892)	1,246,253			16
	C. General Administration											
17	Administrative	73,879		354,286	428,165		428,165	(265,953)	162,212			17
18	Directors Fees											18
19	Professional Services			141,434	141,434	(5,540)	135,894	(75,747)	60,147			19
20	Dues, Fees, Subscriptions & Promotions			34,178	34,178		34,178	(2,577)	31,601			20
21	Clerical & General Office Expense	96,339	17,937	55,937	170,213		170,213	20,508	190,721			21
22	Employee Benefits & Payroll Taxes			251,090	251,090	13,669	264,759	(6,628)	258,131			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,280	1,280		1,280	354	1,634			24
25	Other Admin. Staff Transportation			826	826		826	3,362	4,188			25
26	Insurance-Prop.Liab.Malpractice			52,972	52,972		52,972	1,138	54,110			26
27	Other (specify):*							26,737	26,737			27
28	**TOTAL General Administration**	170,218	17,937	892,003	1,080,158	8,129	1,088,287	(298,806)	789,481			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,504,774	293,259	1,303,407	3,101,440	(5,540)	3,095,900	(377,920)	2,717,980			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $10

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRYN MAWR CARE INC. #0035618 Report Period Beginnin 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,367	56,367		56,367	72,054	128,421			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			806	806		806	402,205	403,011			32
33	Real Estate Taxes			94,119	94,119	5,540	99,659	4,017	103,676			33
34	Rent-Facility & Grounds			575,880	575,880		575,880	(575,880)				34
35	Rent-Equipment & Vehicles			8,172	8,172		8,172	7,618	15,790			35
36	Other (specify):*							8,548	8,548			36
37	**TOTAL Ownership**			735,344	735,344	5,540	740,884	(81,438)	659,446			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transport											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,265	95,265		95,265		95,265			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			95,265	95,265		95,265		95,265			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,504,774	293,259	2,134,016	3,932,049		3,932,049	(459,358)	3,472,691			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Nu: BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	25,229	30		9
10	Interest and Other Investment Income	(30,057)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(31)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(174)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,783)	21		24
25	Fund Raising, Advertising and Promotional	(2,686)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,956)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(50,273)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (86,731)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear i general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(372,627)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (372,627)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B**	$ (459,358)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BRYN MAWR CARE INC.

ID# 0035618

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury duty income	$ (17)	21	1
2	Vending/coin machine income	(426)	35	2
3	Out of cost report period legal fees	(481)	19	3
4	Non-allowable legal expenses	(7,587)	19	4
5	Non-allowable employee benefits	(6,628)	22	5
6	Collection court costs	(96)	21	6
7	Capitalized R&M	(35,038)	6	7
8				8
9				9
10				10
11				11
12				12
13				13
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Num BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(17,810)							(17,810)	1
2	Food Purchase	(31)											(31)	2
3	Housekeeping			576									576	3
4	Laundry													4
5	Heat and Other Utilities			695	1,198								1,893	5
6	Maintenance	(35,038)		516	(9,783)	(10,368)							(54,673)	6
7	Other (specify):*				650	6,173							6,823	7
8	**TOTAL General Services**	(35,069)		1,787	(7,935)	(22,005)							(63,222)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(16,752)								(16,752)	10
10a	Therapy					(4,563)							(4,563)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,296	2,127							5,423	15
16	**TOTAL Health Care and Pro**				(13,456)	(2,436)							(15,892)	16
	C. General Administration													
17	Administrative			13,282	(53,761)	(211,593)		(13,881)					(265,953)	17
18	Directors Fees													18
19	Professional Services	(8,068)		(72,291)	(7,686)	12,201		97					(75,747)	19
20	Fees, Subscriptions & Promoti	(2,860)		67	157			59					(2,577)	20
21	Clerical & General Office Exp	(28,852)		42,134	7,136			90					20,508	21
22	Employee Benefits & Payroll T	(6,628)											(6,628)	22
23	Inservice Training & Educatio													23
24	Travel and Seminar			97	257								354	24
25	Other Admin. Staff Transporta			545	2,817								3,362	25
26	Insurance-Prop.Liab.Malpracti			359	596			183					1,138	26
27	Other (specify):*			7,687	7,709	10,885		456					26,737	27
28	**TOTAL General Administrat**	(46,408)		(8,120)	(42,775)	(188,507)		(12,996)					(298,806)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(81,477)		(6,333)	(64,166)	(212,948)		(12,996)					(377,920)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Numbe BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	25,229	41,189	2,135	3,501								72,054	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(30,057)	428,054	947	3,261								402,205	32
33	Real Estate Taxes			1,299	2,718								4,017	33
34	Rent-Facility & Grounds		(575,880)										(575,880)	34
35	Rent-Equipment & Vehicles	(426)		2,210	4,373			1,461					7,618	35
36	Other (specify):*		8,548										8,548	36
37	TOTAL Ownership	(5,254)	(98,089)	6,591	13,853			1,461					(81,438)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportat													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(86,731)	(98,089)	258	(50,313)	(212,948)		(11,535)					(459,358)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necess

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental income	$ 575,880	Bryn Mawr Care, L.L.C.		$	$ (575,880)	1
2	V	34	Rental income-R/E Taxes	94,115	Bryn Mawr Care, L.L.C.			(94,115)	2
3	V	32	Interest income	156	Bryn Mawr Care, L.L.C.			(156)	3
4	V	34	Real estate tax expense		Bryn Mawr Care, L.L.C.		94,115	94,115	4
5	V	36	Amortization-Nomura fees		Bryn Mawr Care, L.L.C.		8,548	8,548	5
6	V	30	Depreciation		Bryn Mawr Care, L.L.C.		41,189	41,189	6
7	V	32	Mortgage interest-Nomura		Bryn Mawr Care, L.L.C.		428,210	428,210	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 670,151			$ 572,062	$ * (98,089)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Begin 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 576	$ 576	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	695	695	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	516	516	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	13,282	13,282	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,509	1,509	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	67	67	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	42,134	42,134	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	97	97	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	545	545	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	359	359	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	7,687	7,687	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,135	2,135	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	947	947	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,299	1,299	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,210	2,210	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	73,800	PREFERRED BOOKKEEPING	100.00%		(73,800)	32
33	V	19	COMPUTER	4,176	PREFERRED BOOKKEEPING	100.00%	4,176		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 77,976			$ 78,234	$ * 258	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Begin 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,198	$ 1,198	15
16	V	6	REPAIRS AND MAINT.	15,660	S.I.R. MANAGEMENT, INC.	100.00%	5,877	(9,783)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	650	650	17
18	V	10	NURSING	34,452	S.I.R. MANAGEMENT, INC.	100.00%	17,700	(16,752)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,296	3,296	19
20	V	17	ADMINISTRATIVE	61,068	S.I.R. MANAGEMENT, INC.	100.00%	7,307	(53,761)	20
21	V	19	PROFESSIONAL FEES	14,100	S.I.R. MANAGEMENT, INC.	100.00%	6,414	(7,686)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	157	157	22
23	V	21	CLERICAL & GENERAL	17,748	S.I.R. MANAGEMENT, INC.	100.00%	24,884	7,136	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	257	257	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,817	2,817	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	596	596	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	7,709	7,709	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,501	3,501	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,261	3,261	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,718	2,718	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,373	4,373	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 143,028			$ 92,715	$ * (50,313)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Begin 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 17,748	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,174	$ (12,574)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	973	973	16
17	V	17	ADMIN./LEGAL SALARIES	271,618	S.I.R. MANAGEMENT, INC.	100.00%	60,025	(211,593)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	12,201	12,201	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	10,885	10,885	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	15,456	S.I.R. MANAGEMENT, INC.	100.00%	10,893	(4,563)	22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,127	2,127	23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	30,240	S.I.R. MANAGEMENT, INC.	100.00%	19,872	(10,368)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	3,880	3,880	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	6,764	(5,236)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,320	1,320	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 347,062			$ 134,114	$ * (212,948)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Begin 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 68,316	$ 68,316	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	68,316	CCS EMPLOYEE BENEFIT GROUP	100.00%		(68,316)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 68,316			$ 68,316	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Begin 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 97	$ 97	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	59	59	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	90	90	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	183	183	18
19	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	1,461	1,461	19
20	V	17	MANAGEMENT FEES	21,600	ECM OWNERS COUNCIL	100.00%		(21,600)	20
21	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	7,719	7,719	21
22	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	456	456	22
23	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,600			$ 10,065	$ * (11,535)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Begin 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Begin 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Begin 01/01/01 Ending 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work					
					Compensation	Week Devoted to this		Compensation Included		Schedule V.	
					Received	Facility and % of Total		in Costs for this		Line &	
				Ownership	From Other	Work Week		Reporting Period**		Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Bryan Barrish	Stockholder	Administrative	27.00%	See attached	3.78	8.40%	Alloc. Salary	$ 15,769	17-7	1
2	Mike Giannini	Stockholder	Administrative	1.44%	See attached	3.78	8.40%	Alloc. Salary	15,876	17-7	2
3	Arturo Rominiquit	Relative	Clerical	0	See attached	3.42	8.55%	Alloc. Salary	1,935	21-7	3
4	Nenita Guzman	Relative	Dietary	0	See attached	4.72	9.44%	Alloc. Salary	5,174	1-7	4
5	Eric Rothner	Stockholder	Administrative	46.55%	See attached	.60	0.01%	Alloc. Salary	1,455	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 40,209		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedul of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES'

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fee FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizati PREFERRED BOOKEEPING SERVICE
Street Address 4100 WEST PRATT AVE.
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 674-5200
Fax Number (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOM	863,792	11	$ 6,745	$	73,800	$ 576	1
2	5	UTILITIES	BOOK./ACCNT.INCOM	863,792	11	8,137		73,800	695	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOM	863,792	11	6,035		73,800	516	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOM	863,792	11	155,464	155,464	73,800	13,282	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOM	863,792	11	17,663		73,800	1,509	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOM	863,792	11	788		73,800	67	6
7	21	CLERICAL	BOOK./ACCNT.INCOM	863,792	11	493,157	432,172	73,800	42,134	7
8	24	SEMINARS	BOOK./ACCNT.INCOM	863,792	11	1,135		73,800	97	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOM	863,792	11	6,379		73,800	545	9
10	26	INSURANCE	BOOK./ACCNT.INCOM	863,792	11	4,205		73,800	359	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOM	863,792	11	89,973		73,800	7,687	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOM	863,792	11	24,993		73,800	2,135	12
13	32	INTEREST	BOOK./ACCNT.INCOM	863,792	11	11,085		73,800	947	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOM	863,792	11	15,206		73,800	1,299	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOM	863,792	11	25,868		73,800	2,210	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						4,176	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 866,833	$ 587,636		$ 78,234	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizati S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	629,428	10	$ 12,680	$	59,460	$ 1,198	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	629,428	10	62,210	44,382	59,460	5,877	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	629,428	10	6,878		59,460	650	3
4	10	NURSING	PATIENT DAYS	629,428	10	187,368	187,368	59,460	17,700	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	629,428	10	34,893		59,460	3,296	5
6	17	ADMINISTRATIVE	PATIENT DAYS	629,428	10	77,349	77,349	59,460	7,307	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	629,428	10	67,899		59,460	6,414	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	629,428	10	1,658		59,460	157	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	629,428	10	263,413	213,455	59,460	24,884	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	629,428	10	2,720		59,460	257	10
11	25	OTHER ADMIN. STAFF T	PATIENT DAYS	629,428	10	29,820		59,460	2,817	11
12	26	INSURANCE	PATIENT DAYS	629,428	10	6,309		59,460	596	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	629,428	10	81,605		59,460	7,709	13
14	30	DEPRECIATION	PATIENT DAYS	629,428	10	37,059		59,460	3,501	14
15	32	INTEREST	PATIENT DAYS	629,428	10	34,524		59,460	3,261	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	629,428	10	28,776		59,460	2,718	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	629,428	10	46,289		59,460	4,373	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 981,450	$ 522,555		$ 92,715	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizati S.I.R. MANAGEMENT, INC.
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 675 -7979
Fax Number (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	629,428	10	$ 54,767	$ 54,767	59,460	$ 5,174	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	629,428	10	10,305		59,460	973	2
3	17	ADMIN./LEGAL SALARIE	PATIENT DAYS	629,428	10	635,411	635,411	59,460	60,025	3
4	19	FINANCIAL CONSULTAN	PATIENT DAYS	629,428	10	129,159		59,460	12,201	4
5	27	EMP. BEN.-ADMINISTRA	PATIENT DAYS	629,428	10	$ 115,229	$	59,460	$ 10,885	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	58,457	58,457	15,456	10,893	8
9	15	EMP. BEN.-HEALTH CAR	SPECIAL REHAB INC.	82,944	4	$ 11,413	$	15,456	$ 2,127	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	221,184	10	145,348	145,348	30,240	19,872	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	221,184	10	$ 28,377	$	30,240	$ 3,880	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE I	125,400	10	70,679	70,679	12,000	6,764	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE I	125,400	10	13,799		12,000	1,320	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,272,944	$ 964,662		$ 134,114	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizati CCS EMPLOYEE BENEFITS GROUP,
Street Address 4101 W. MAIN ST.
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 674-1180
Fax Number (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS	DIRECT ALLOCATION			$	$		$ 68,316	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 68,316	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizati ECM OWNERS COUNCIL
Street Address 6840 N. LINCOLN
City / State / Zip Code LINCOLNWOOD, IL. 60646
Phone Number (847) 676-2026
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE	96,000	9	$ 430	$	21,600	$ 97	1
2	20	DUES, FEES & SUBSCRIP	ECMOC MGMNT FEE	96,000	9	264		21,600	59	2
3	21	CLERICAL	ECMOC MGMNT FEE	96,000	9	400		21,600	90	3
4	26	INSURANCE	ECMOC MGMNT FEE	96,000	9	813		21,600	183	4
5	35	VEHICLE RENTAL	ECMOC MGMNT FEE	96,000	9	6,493		21,600	1,461	5
6	17	MANAGEMENT FEES	ECMOC MGMNT FEE	96,000	9			21,600		6
7	17	ADMIN. SAL. - M. GIANNI	ADMIN. HOURS	39	9	79,839	79,839	4	7,719	7
8	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,713		4	456	8
9	17	ADMIN. SALARY	DIRECT ALLOCATION		6	(539)				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,413	$ 79,839		$ 10,065	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 2/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage	$42,679	3/1/96	$ 5,217,000	$ 4,819,386	3/1/08	8.69%	$ 428,210	1
2												2
3												3
4												4
5												5
	Working Capital											
6			X	Insurance financing							806	6
7												7
8												8
9	TOTAL Facility Related				$42,679		$ 5,217,000	$ 4,819,386			$ 429,016	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										4,208	10
11	Interest income	X									(30,057)	11
12	Interest income		X								(156)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (26,005)	14
15	TOTALS (line 9+line14)						$ 5,217,000	$ 4,819,386			$ 403,011	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocated from Preferred B	X					$	$			$ 947	1
2	Allocated from S.I.R. Mgm	X									3,261	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 4,208	21

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	110,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below	$	104,736	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,664)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	103,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with th	$	5,540	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	103,676	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year	1996	123,120	8
	1997	111,190	9
	1998	113,164	10
	1999	107,001	11
	2000	100,719	12

2001 accrual = $100,719 x estimated 3% increase = $103,800

Allocated from S.I.R. Properties-S.I.R. Management $2,718

Allocated from S.I.R. Properties-Preferred Bookkeeping $1299

$5,540 is the direct cost for 2000 tax assessment reduction.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCU	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRYN MAWR CARE INC. COUNTY COOK

FACILITY IDPH LICENSE NUM 0035618

CONTACT PERSON REGARDING THIS I Steve Lavenda

TELEPHON (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter on cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any p home property which is vacant, rented to other organizations, or used for purposes other than long term entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-202-002	Long term care property	$ 97,176.02	$ 97,176.02
2.	14-08-202-003	Long term care property	$ 3,543.46	$ 3,543.46
3.	See attached	S.I.R. Mangement allocation	$ 64,023.09	$ 4,132.32
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 164,742.57	$ 104,851.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property whi used for nursing home service: X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nur (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space use

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the is normally paid during 2001.

Facility Name & ID Nu: BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,120 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1989	$ 63,070	1
2					2
3	TOTALS			$ 63,070	3

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1989	$ 1,443,623	$	35	$ 41,246	$ 41,246	$ 512,138	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	3,323		20	133	133	1,629	9
10	Various			1990	21,607		20	1,081	1,081	12,461	10
11	Various			1991	99,075		20	4,955	4,955	51,343	11
12	Various			1992	37,297		20	1,865	(1,865)	18,240	12
13	Various			1993	18,516		20	853	853	8,947	13
14	Various			1994	33,458		20	2,429	2,429	17,923	14
15	Various			1995	64,419		20	3,497	3,497	22,904	15
16	Various			1996	130,280		20	6,513	6,513	35,974	16
17	Various			1997	184,919		20	8,842	8,842	39,659	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		74,348	43,954		2,929	(41,025)	25,392	68
69	Financial Statement Depreciation			56,367			(56,367)		69
70	TOTAL (lines 4 thru 69)		$ 2,110,865	$ 100,321		$ 74,343	$ (29,708)	$ 746,610	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,110,865	$ 100,321		$ 74,343	$ (25,978)	$ 746,610	1
2	FLOORING	1998	7,789		20	389	389	1,556	2
3	BATHROOM REMODEL	1998	4,252		20	213	213	834	3
4	DOORS	1998	2,079		20	104	104	381	4
5	ELEVATOR	1998	33,640		20	1,682	1,682	6,027	5
6	DOORS	1998	1,076		20	54	54	194	6
7	FIRE ALARM	1998	74,900		20	3,745	3,745	13,420	7
8	OUTDOOR LIGHTING	1998	4,300		20	215	215	735	8
9	WOLF ROOFING	1998	15,500		20	775	775	2,583	9
10	WOLF ROOFING	1998	18,000		20	900	900	2,925	10
11	BOILER CONTROLLER	1998	2,228		20	111	111	435	11
12	PAINTING	1998	5,200		20	260	260	975	12
13	TUCKPOINTING	1998	2,600		20	130	130	433	13
14	SIR MGMT ALLOC	1999	9,735		20	487	487	1,136	14
15	FIRE DOORS (22)	1999	29,826		20	1,491	1,491	3,106	15
16	WINDOWS	2000	99,727		20	4,986	4,986	9,557	16
17	WATER HEATER	2000	4,100		20	205	205	239	17
18	A/C WORK	2000	3,360		20	168	168	238	18
19	DOOR MONITORING	2000	2,199		20	106	106	141	19
20	ELECTRIC WIRING	2000	1,046		20	54	54	68	20
21	ELECTRICAL	2000	5,702		20	285	285	309	21
22	ROOF	2000	4,300		20	215	215	233	22
23	MEDICINE CABINET	2000	2,290		20	115	115	115	23
24	PLUMBING WORK	2001	7,990		20	400	400	400	24
25	LOBBY HVAC	2001	4,320		20	126	126	126	25
26	LIGHTING	2001	5,408		20	135	135	135	26
27	WATER RISER	2001	6,858		20	172	172	172	27
28	FLOORING	2001	22,758		20	1,138	1,138	1,138	28
29	FLOORING	2001	2,128		20	53	53	53	29
30	ELEVATOR WORK	2001	5,690		20	119	119	119	30
31	ELEVATOR CABLES	2001	7,750		20	97	97	97	31
32	N. STATION WORK	2001	31,472		20	262	262	262	32
33	BLINDS	2001	6,183		20	309	309	309	33
34	TOTAL (lines 1 thru 33)		$ 2,545,271	$ 100,321		$ 93,844	$ (6,477)	$ 795,061	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb(BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,545,271	$ 100,321		$ 93,844	$ (6,477)	$ 795,061	1
2	TILING	2001	949		20	47	47	47	2
3	ROOFING	2001	2,890		20	145	145	145	3
4	DOWNSPOUT	2001	2,670		20	134	134	134	4
5	TUCKPOINTING	2001	2,500		20	125	125	125	5
6	BATHTUB RENOVATIONS	2001	1,150		20	58	58	58	6
7	ROOFING	2001	1,980		20	99	99	99	7
8	ELECTRICAL WORK	2001	2,720		20	136	136	136	8
9	AIR CONDITIONERS	2001	2,702		20	135	135	135	9
10	AIR CONDITIONERS	2001	1,771		20	89	89	89	10
11	TILING	2001	1,263		20	63	63	63	11
12	PAINTING	2001	385		20	19	19	19	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb(BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb(BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb(BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb(BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb(BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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17									17
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19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,566,251	$ 100,321		$ 94,894	$ (5,427)	$ 796,111	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 12,064	$ 383	35	$ 345	$ (38)	$ 2,930	4
5			1993		25,242	801	35	721	(80)	6,130	5
6											6
7											7
8											8
	Improvement Type**										
9	Bryn Mawr Care, L.L.C.					41,189			(41,189)		9
10											10
11	Allocated from S.I.R. Management			1993	10,841	302	20	547	245	10,902	11
12	Allocated from S.I.R. Management			1994	34	-	20	8	(8)	56	12
13	Allocated from S.I.R. Management			1995	248	-	20	12	12	79	13
14	Allocated from S.I.R. Management			1999	1,178	56	20	59	3	130	14
15	Allocated from S.I.R. Management			2000	711	124	20	36	(88)	60	15
16											16
17	Allocated from Preferred Bookkeeping			1997	15,066	337	20	753	416	3,623	17
18	Allocated from Preferred Bookkeeping			1999	120	23	20	6	(17)	15	18
19	Allocated from Preferred Bookkeeping			2000	756	-	20	38	38	53	19
20											20
21	Allocated from S.I.R. Properties-S.I.R. Management			1999	3,199	320	20	160	(160)	400	21
22	Allocated from S.I.R. Properties-S.I.R. Management			1998	1,529	153	20	76	(77)	267	22
23	Allocated from S.I.R. Properties-S.I.R. Management			1997	95	10	20	5	(5)	26	23
24	Allocated from S.I.R. Properties-S.I.R. Management			1994	240	6	20	12	6	90	24
25	Allocated from S.I.R. Properties-S.I.R. Management			1993	409	11	20	20	9	174	25
26											26
27	Allocated from S.I.R. Properties-Preferred Bookkeeping			1999	1,529	153	20	76	(77)	191	27
28	Allocated from S.I.R. Properties-Preferred Bookkeeping			1998	731	73	20	37	(36)	128	28
29	Allocated from S.I.R. Properties-Preferred Bookkeeping			1997	45	5	20	2	(3)	12	29
30	Allocated from S.I.R. Properties-Preferred Bookkeeping			1994	115	3	20	6	3	43	30
31	Allocated from S.I.R. Properties-Preferred Bookkeeping			1993	196	5	20	10	5	83	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 74,348	$ 43,954		$ 2,929	$ (41,041)	$ 25,392	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Compone Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 342,805	$ 2,750	$ 31,213	$ 28,463	10	$ 199,062	71
72	Current Year Purchases	35,200	121	1,671	1,550	10	1,671	72
73	Fully Depreciated Assets	180,838				10	180,838	73
74								74
75	TOTALS	$ 558,843	$ 2,871	$ 32,884	$ 30,013		$ 381,571	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years	Accumulated Depreciation 9	
76		1998 CHEVY VAN	2001	$ 15,436	$	$ 643	$ 643	5	$ 643	76
77										77
78										78
79										79
80	TOTALS			$ 15,436	$	$ 643	$ 643		$ 643	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,203,600	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	103,192	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	128,421	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	25,229	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,178,325	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreemen
Beginning
Ending

11. Rent to be paid in future years under the
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipmen 8,524 Description: See attached schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Preferred Bookkeeping		$	$ 1,656	17
18	Allocation from S.I.R. Management			4,150	18
19	Allocation from Extended Care Management			1,461	19
20					20
21	TOTAL		$	$ 7,267	21

* If there is an option to buy the building, please provide complete details on attach schedule.

** This amount plus any amortization of lea expense must agree with page 4, line 34.

Facility Name & ID Number BRYN MAWR CARE INC. # 0035618 Report Period Beginning 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that fa

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ___

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income facility received training aides from other faci

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Numbe: BRYN MAWR CARE INC. # 0035618 Report Period Beginnin 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 49,505	$ 54,755	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,072,671	1,072,671	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,624	7,624	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related par	60,195	60,195	8
9	Other(specify) See supplemental schedule	37,071	37,071	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,227,066	$ 1,232,316	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		207,475	13
14	Buildings, at Historical Cost		1,443,623	14
15	Leasehold Improvements, at Historical Cost	630,947	630,947	15
16	Equipment, at Historical Cost	897,128	897,128	16
17	Accumulated Depreciation (book methods)	(867,804)	(1,525,018)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify) See supplemental schedule	47,095	99,448	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 707,366	$ 1,753,603	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,934,432	$ 2,985,919	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 94,206	$ 94,207	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,994	28,994	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,329	113,329	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,116	9,116	31
32	Accrued Real Estate Taxes(Sch.IX-	103,800	103,800	32
33	Accrued Interest Payable		24,430	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	23,400	23,400	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	8,550	8,550	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 381,395	$ 405,826	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,819,386	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(spec			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,819,386	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 381,395	$ 5,225,212	46
47	**TOTAL EQUITY(page 18, line**	$ 1,553,037	$ (2,239,293)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,934,432	$ 2,985,919	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reporte**	$ 1,312,309	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of li**	$ 1,312,309	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,215,128	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(974,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 240,728	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17**	$ 1,553,037	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Nun BRYN MAWR CARE INC. # 0035618 Report Period Beginning 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,115,477	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line**	$ 5,115,477	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,057	25
26	**SUBTOTAL Non-Operating Revenue (lines 2**	$ 30,057	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, E**		27
28	See supplemental schedule	1,643	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and**	$ 1,643	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 a**	$ 5,147,177	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	759,137	31
32	Health Care	1,262,145	32
33	General Administration	1,080,158	33
	B. Capital Expense		
34	Ownership	735,344	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	95,265	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,932,049	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,215,128	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 mi**	$ 1,215,128	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,594	1,749	$ 45,589	$ 26.07	1
2	Assistant Director of Nursing	1,748	2,029	39,444	19.44	2
3	Registered Nurses	690	690	14,609	21.17	3
4	Licensed Practical Nurses	10,355	11,329	178,232	15.73	4
5	Nurse Aides & Orderlies	48,556	51,517	430,730	8.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,819	2,086	23,248	11.14	9
10	Activity Assistants	11,528	12,400	93,421	7.53	10
11	Social Service Workers	13,307	14,267	180,666	12.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,152	4,364	37,924	8.69	14
15	Cook Helpers/Assistants	11,318	12,224	98,114	8.03	15
16	Dishwashers					16
17	Maintenance Workers	1,915	2,086	40,541	19.43	17
18	Housekeepers	14,319	15,134	100,489	6.64	18
19	Laundry					19
20	Administrator	1,892	2,086	73,879	35.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,571	8,507	96,339	11.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,539	3,881	51,549	13.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,303	144,349	$ 1,504,774 *	$ 10.42	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 12,000	01-03	35
36	Medical Director	72	3,600	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant	Monthly	34,452	10-03	38
39	Pharmacist Consultant	Monthly	1,440	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,221	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Consultant Specialized Rehab	Monthly	15,456	10a-03	47
48	Food service consultant	Monthly	17,748	01-03	48
49	TOTAL (lines 35 - 48)	215	$ 90,949		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	5,975	115,609	10-03	52
53	TOTAL (lines 50 - 52)	5,975	$ 115,609		53

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augusto Beley	Administrator	0	$ 71,179
Martin Lee	Administrator	0	2,700
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,879

B. Administrative - Other

Description	Amount
Management fees-S.I.R. Management	$ 271,618
Director of Administrative Services-S.I.R. Management	21,924
Ancillary administrative charges-S.I.R. Management	39,144
Owners council dues-Extended Care Management	21,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 354,286
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See attached schedule	Legal	$ 28,550
Preferred bookkeeping	Accounting	21,600
Frost Ruttenberg & Rothblatt	Accounting	12,703
Preferred bookkeeping	Computer services	4,176
Personnel Planners	Unemployment consultant	1,040
S.I.R. Management	Director of Regulatory Svc	14,100
Preferred bookkeeping	Bookkeeping services	52,200
Preferred bookkeeping	Computer services	1,320
Art Roseau	Directors fees	125
ICS Solutions	Computer services	80
Preferred bookkeeping	Real estate tax services	5,540
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices		$ 141,434

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 10,632
Unemployment Compensation Insurance	15,174
FICA Taxes	112,773
Employee Health Insurance	44,308
Employee Meals	13,669
Illinois Municipal Retirement Fund (IMRF)*	
Union health and welfare	49,945
401k contributions	3,650
Employee benefits	4,344
Chicago Head Tax	3,636
TOTAL (agree to Schedule V, line 22, col.8)	$ 258,131

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	17,650
Health Care Worker Background C	834
(Indicate # of checks perfor 119)	
Advertising and promotion	2,686
Dues and subscriptions	7,789
Licenses	4,645
Allocated from Preferred/SIR/ECM	283
Less: Public Relations Expense	
Non-allowable advertising	(2,686)
Yellow page advertising	
TOTAL (agree to Sch. ' line 20, col. 8)	$ 31,601

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,280
Allocated from Preferred	97
Allocated from S.I.R. Management	257
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,634

**See instructions.

Facility Name & ID Numb BRYN MAWR CARE INC. # 0035618 Report Period Beginning 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a unio **Yes**

(2) Are there any dues to nursing home associations included on the co **Yes**
If YES, give association name and ar **Illinois Council on LTC $7369**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal yea **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment pur **Yes**
What was the average life used for new equipment added during th **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. **1,186** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior report **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arran **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII YES NO **X** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departm of Public Aid during this cost report period. **95,265**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifi in the Ancillary Section of Schedule V **N/A**

(14) Is a portion of the building used for any function other than long term care servic the patient census listed on page 2, Se **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, a a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benef on Schedule V. $ **13,669** Has any meal income been offset against related costs? **No** Indicate the amou $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state trav **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical trans residents? **No** If YES, please indicate the amount of income earned from program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses **100% In 1**
d. Have vehicle usage logs been maint **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day train No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accou **No**
Firm Name: The instructions for t cost report require that a copy of this audit be included with the cost report. Has been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjuste out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of s performed been attached to this cost r **Yes**
Attach invoices and a summary of services for all architect and appraisal fees